BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Calvin S. Steever, M.D. Certificate # C-20726 Respondent.	D-3740

DECISION

The attached Stipulation is hereby adopted by the Division of Medical Quality of the Board of Medical Quality Assurance as its Decision in the above-entitled matter.

This Decision shall become effective on January 5, 1989.

IT IS SO ORDERED December 6, 1988.

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

Theresa Claassen

THERESA CLAASSEN
Secretary-Treasurer

JOHN K. VAN DE KAMP, Attorney General
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BEFORE THE
BOARD OF MEDICAL QUALITY ASSURANCE
DIVISION OF MEDICAL QUALITY
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CALVIN STANLEY STEEVER, M.D. 3859 Montgomery Drive Santa Rosa, California 95402 Certificate No. C-20726 Respondent.	No. D-3740 PROPOSED DECISION PURSUANT TO STIPULATION

IT IS HEREBY STIPULATED by and between Calvin Stanley Steever, M.D. (hereinafter "respondent") by and through his attorney, John A. Waner, and the Division of Medical Quality, Board of Medical Quality Assurance, State of California (hereinafter, "the Division") by and through its attorney John K. Van De Kamp, Attorney General of the State of California by Vivien Hara Hersh, Deputy Attorney General and Alfredo Terrazas, Deputy Attorney General as follows:

1. Respondent has received and read the accusation which is presently on file and pending in case No. D-3740 before The Division.

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2. Kenneth J. Wagstaff, complainant, is the Executive Director of the Board of Medical Quality Assurance, State of California and made and filed said accusation solely in his official capacity.

3. Respondent's license history and status as set forth in paragraph 2 of the accusation is true and correct.

4. Respondent understands that the charges alleged in the above-mentioned Accusation No. D-3740, if proven, would constitute grounds for disciplinary action. A true and correct copy of said accusation is attached hereto and designated "Exhibit A."

5. Respondent has fully discussed the charges and allegations contained in Accusation No. D-3740 with his counsel and therefore has been fully advised with regard to his rights in this matter.

6. Respondent is fully aware of his right to a hearing on the charges and allegations contained in said accusation, his right to reconsideration, appeal, and any and all other rights which may be accorded him pursuant to the California Administrative Procedure Act and other laws of the State of California.

7. Respondent freely and voluntarily waives his right to a hearing, reconsideration, appeal, and any and all other rights which may be accorded him by the California Administrative Procedure Act and other laws of the State of California with regard to Accusation No. D-3740, excepting his right to petition

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for modification or termination of probation under Business and Professions Code section 2307.

8. All admissions of fact and conclusions of law contained in this stipulation are made exclusively for this proceeding and any future proceedings between the Division and the respondent or the Board of Medical Quality Assurance and respondent, and they shall not be deemed admissions for any purpose in any other administrative, civil or criminal action, forum or proceeding.

9. For purposes of the settlement of the action pending against respondent in case No. D-3740, and, to avoid a lengthy administrative hearing that would impose severe economic hardship upon respondent, respondent admits that there is a factual basis for the imposition of discipline based on the totality of the allegations charged in the Accusation. Respondent neither admits nor denies, but does not contest, the truth and accuracy of the allegations contained in the causes for disciplinary action of said Accusation and further acknowledges that pursuant to his recitals hereinabove, cause exists for disciplinary action pursuant to Business and Professions Code sections 2234(b), (c) and/or (d), and 2238, 2241 and 2242.

10. Based upon the foregoing recitals, IT IS HEREBY STIPULATED AND AGREED that the Division may issue, as to said grounds for disciplinary action, the following order:

Certificate No. C-20726, issued to respondent herein by the Board of Medical Quality Assurance, is hereby revoked; **provided, however,** that said revocation is stayed for a period of

five (5) years, during which time respondent shall be placed upon probation, subject separately and severally to the following terms and conditions.

a. As part of probation, respondent is suspended from the practice of medicine for 90 days beginning on the effective date of this decision.

During this suspension, respondent shall be totally prohibited from practicing medicine except within the context of and under the supervision of the intensive clinical training program required in paragraph 10(b), below, if such program is commenced during the suspension period.

b. Within 90 days of the effective date of this decision, respondent shall submit to the Division for its prior approval, an intensive clinical training program in family practice. The exact number of hours and the specific content of the program shall be determined and approved by the Division or its designee. Respondent shall successfully complete the training program.

c. During the final 30 days of his suspension period, or at such other time after said final 30 days as the Division may approve, respondent shall take and pass an oral clinical examination in family practice, including obstetrics and prescription practices to be administered by the Division or its designee. If respondent fails this examination, he must take and pass a re-examination consisting of a written as well as an oral clinical examination. The waiting period between repeat examinations shall be at three month intervals until success is achieved. The Division shall pay the cost of the first

examination and respondent shall pay the cost of any subsequent re-examinations.

Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Division in writing.

d. Respondent shall maintain carbon copies of all controlled substances and dangerous drugs prescribed, dispensed or administered by respondent during probation, showing all the following: 1) the name and address of the patient, 2) the date, 3) the character and quantity of controlled substance was furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order, and shall make them available for inspection and copying by the Division or its designee, upon request.

e. Within 30 days of the effective date of this decision, respondent shall submit to the Division for its prior approval a plan of practice in which respondent's practice shall be monitored by another physician in respondent's field of practice, who shall provide periodic reports to the Division.

If the monitor withdraws, or is no longer available, respondent shall not practice until a new monitor has been substituted, through nomination by respondent and approval by the Division.

f. Within 90 days after the first full year of probation, and on an annual basis thereafter, respondent shall submit to the Division for its prior approval an educational

program or course related to family practice which shall not be less than 40 hours per year, for each remaining year of probation. This program shall be **in addition to** the Continuing Medical Education requirement for re-licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of continuing medical education of which 40 hours were in satisfaction of this condition and were approved in advance by the Division.

g. During probation, respondent is prohibited from practicing obstetrics and major gynecological surgery.

h. Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in California.

i. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

j. Respondent shall comply with the Division's probation surveillance program.

k. Respondent shall appear in person for interviews with the Division's medical consultant upon request at various intervals and with reasonable notice.

l. The period of probation shall not run during the time respondent is residing or practicing outside the jurisdiction of California. If, during probation, respondent moves out of the

jurisdiction of California to reside or practice elsewhere, respondent is required to immediately notify the Division in writing of the date of departure, and the date of return, if any.

m. Upon successful completion of probation, respondent's certificate will be fully restored.

n. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. IT IS FURTHER STIPULATED AND AGREED that the terms set forth herein shall be null and void, and in no way binding upon the parties hereto, unless and until accepted by the Division of Medical Quality, Board of Medical Quality Assurance, State of California as its decision in this matter.

DATED: Sept 9 1988

JOHN K. VAN DE KAMP
Attorney General of the
State of California

Vivien Hara Hersh

VIVIEN HARA HERSH
Deputy Attorney General

Alfredo Terrazas

ALFREDO TERRAZAS
Deputy Attorney General

Attorneys for Complainant

DATED: Sept 1, 1988

JOHN A. WANER, Esq.
Attorney for Respondent

I hereby certify that I have read this stipulation and agreement in its entirety, that my attorney of record has fully explained the legal significance and consequences thereof, that I fully understand all of the same, and in witness thereof I affix my signature this 1ST day of SEPT., 1988 at SANTA ROSA, California.

CALVIN STANLEY STEEVER, M.D.
Respondent

03573110-SF86AD1563

COPY

JOHN K. VAN DE KAMP, Attorney General
of the State of California
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BEFORE THE
BOARD OF MEDICAL QUALITY ASSURANCE
DIVISION OF MEDICAL QUALITY
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CALVIN STANLEY STEEVER, M.D. 3859 Montgomery Drive Santa Rosa, California 95402 Certificate No. C-20726 Respondent.	No. D-3740 ACCUSATION

KENNETH J. WAGSTAFF, complainant herein, charges and alleges as follows:

1. He is the Executive Director of the Board of Medical Quality Assurance, State of California (hereinafter "the Board") and makes these charges and allegations solely in his official capacity.

2. At all times mentioned herein, respondent Calvin Stanley Steever, M.D. (hereinafter "respondent") has held physician and surgeon certificate No. C-20726, which was issued to him by the Board on or about June 10, 1959, and is in current

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status at the present time. No prior disciplinary action has been taken against said certificate.

3. Section 2220 of the Business and Professions Code [1/] provides that the Division of Medical Quality of the Board (hereinafter "the Division") may take action against all persons guilty of violating the provisions of the Medical Practices Act (Business and Professions Code sections 2000 et seq.).

4. Section 2234 provides, in pertinent part, that the Division shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct is defined therein to include, but not to be limited to: (a) violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of the Medical Practice Act, (b) gross negligence, (c) repeated negligent acts, (d) incompetence, and (e) the commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions or duties of a physician and surgeon.

FIRST CAUSE FOR DISCIPLINARY ACTION

5. On or about May 26, 1981, respondent saw in his office patient N.A.S., a 35 year old primagravida at 36 weeks gestation with the fetus in breech presentation. Respondent performed an external version of the fetus from breech to vertex presentation, thereby risking injury to the umbilical cord and placenta.

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1. All statutory references are to the Business and Professions Code unless otherwise indicated.

6. On or about July 21, 1981 at 11:00 p.m., N.A.S. was referred by her midwife to respondent's care at Santa Rosa Memorial Hospital because of arrested labor. She had been in labor for approximately 18 hours. The patient was admitted exhausted but with moderate to strong contractions; despite this, respondent elected to administer IV pitocin with the fetal monitor indicating deceleration. Decelerations became progressively more severe with the pitocin, and at 2:25 a.m. on July 22, 1981, respondent elected to perform a caesarian section, but no operating room was available for 30 minutes.

7. The patient was then allowed to push and developed severe and prolonged bradycardia. She was rushed to the delivery room, mid-forceps were applied and an Apgar 2 and 5 infant was delivered at 2:59 a.m. with a nucal cord and thick meconeum. The pediatrician had not been called and respondent resuscitated the infant with suction, mouth-to-mouth resuscitation and oxygen. The pediatrician arrived 30 minutes later, and the infant was diagnosed as having meconeum aspiration with severe birth asphyxia. N.A.S. went into shock due to blood loss immediately after delivery.

8. Respondent's management and care of patient N.A.S. and/or her fetus/infant as above described constitutes gross negligence and/or negligence and/or incompetence and therefore is cause for disciplinary action pursuant to section 2234(b), (c) and/or (d).

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SECOND CAUSE FOR DISCIPLINARY ACTION

9. On or about September 22, 1982, respondent undertook to care for and treat C.V. [2/] a 35 year old primagravida at approximately 28 weeks gestation. Patient records show only eight prenatal visits with notations of weight only. Respondent did not perform a history and physical examination or obtain previous office records.

10. On or about December 6, 1982 at 7:00 a.m., C.V. was admitted to Santa Rosa Memorial Hospital after being in early labor for 12 hours. Membranes ruptured at 7:30 a.m., and meconeum staining was noted by the nurse at that time and several times during labor but respondent denied this was the case. An internal fetal monitor was applied at 2:30 p.m., but removed because of patient discomfort; a nurse noted signs of fetal distress, but respondent denied this. IV pitocin was started at 2:40 p.m., the monitor reapplied and a scalp electrode placed. This showed poor variability with repeated subtle late deceleration, which were not noted by respondent. At the patient's insistence, after consultation with an obstetrician, a caesarian section was performed and an Apgar 4 and 5 female infant was delivered at 8:03 a.m. on December 7, 1982. The infant developed meconeum aspiration, complicated by birth asphyxia and septic pneumonitis.

11. Respondent's care and management of patient C.V. and/or her fetus/infant girl constitutes gross negligence and/or

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2. Respondent will be given the full names of all patients pursuant to any request for discovery.

negligence and/or incompetence and therefore is cause for disciplinary action pursuant to section 2234(b), (c) and/or (d).

THIRD CAUSE FOR DISCIPLINARY ACTION

12. On or about December 20, 1983, at approximately 7:00 a.m., C.B., a 26-year old primagravida at term, was referred by her midwife to respondent at Santa Rosa Memorial Hospital for arrested labor. C.B. had been in labor for 24 hours, had had ruptured membranes for about six hours, and was five cm dilated with little progress in terms of descent (0 station).

At 9:00 a.m., a caesarian section was recommended by consult. C.B. at noon was noted to have a high white blood cell count and there was fetal tachycardia. No enhancement of labor was attempted, and after observation of C.B. with no progress noted and no fetal monitoring, a caesarian section was performed later that afternoon.

13. Post-operatively, C.B. had a fever of 103.2 degrees F. Foul smelling amniotic fluid had been noted, and therefore respondent placed C.B. on Claforan, a broad spectrum antibiotic; C.B. had a fever of 100.5 degrees F the next day, but was essentially afebrile for the next two days; then fevers recurred. On December 24, 1983, despite the fevers, respondent discontinued Claforan and placed C.B. on a narrower spectrum antibiotic, Unipen. Unipen was discontinued on December 28, 1983, and C.B. was started on Amoxicillin, another narrower spectrum antibiotic. The nurses had noted for several days that the patient had foul-smelling lochia and abdominal tenderness, and C.B. developed erythema above the wound margin. Respondent

discharged C.B. on Amoxicillin on December 29, 1983 despite the fact that she had a fever of 102 degrees F at noon that day. A week later, a wound abscess was opened and drained by respondent.

14. Respondent's management and care of patient C.B. as described above constitutes gross negligence and/or negligence and/or incompetence and therefore is cause for disciplinary action pursuant to section 2234(b), (c) and/or (d).

FOURTH CAUSE FOR DISCIPLINARY ACTION

15. On or about January 24, 1984 at approximately 11:30 a.m., B.J.G., a 22 year old primagravida at term, was admitted to Community Hospital in Santa Rosa. Respondent was notified since he had followed B.J.G. prenatally; examination in his office just before admission indicated she was 4 cm. dilated, and leaking amniotic fluid. She had been in labor for 3 or 4 days prior to admission. Hospital nurses notes indicate that meconeum-stained amniotic fluid was noted at 9:00 a.m. Labor progressed slowly, and B.J.G. was considered fully dilated about 6:00 p.m., with slow progress until 9:00 p.m., when she was transferred to the delivery room. Respondent failed to order fetal monitoring or labor augmentation and failed to consider the observation of meconeum.

16. At delivery, a tight nucal cord was noted, but respondent made no attempt to clamp or ligate the cord. No labor augmentation or caesarian section was considered even at this time. There was thick meconeum and great difficulty delivering the infant; low-mid forceps were applied to deliver the infant at about 10:30 p.m. Apgars were 1 and 2 at birth, and the infant

had a fractured clavicle, neonatal asphyxia, meconeum aspiration, and Erb's palsy as a direct consequence of delivery.

17. B.J.G.'s hematocrit dropped to 24.7% on the first postpartum day as a result of her condition and management at delivery and she developed orthostatic changes. The infant was immediately transferred to the intensive care unit, and was respirator-dependent due to bilateral phrenic nerve palsy until May 1984, when she underwent surgery to correct a paralyzed left diaphragm and massive esophageal reflux with pulmonary failure requiring respiratory support at the University of California Medical Center in San Francisco.

18. Respondent's management and care of patient B.J.G. and her fetus/infant girl as described above constitutes gross negligence and/or negligence and/or incompetence and therefore is cause for disciplinary action pursuant to section 2234(b), (c) and/or (d).

FIFTH CAUSE FOR DISCIPLINARY ACTION

19. On or about September 9, 1984 at approximately 1:30 p.m., D.V. a 17 year old primagravida, was admitted to Santa Rosa Memorial Hospital for spontaneous vaginal delivery of a male child on September 9, 1984 at approximately 10:00 p.m. Respondent attended the uneventful delivery. Following delivery, the patient was noted to have heavy bleeding and complained of perineal pain and pressure. A hematoma on the right labia was noted. At 11:00 p.m., respondent repaired a vaginal laceration, but the patient complained of severe pain, and on the following day, the hematoma was 10 x 30 cm and had extended to the left

labia and the left buttock. Respondent saw the patient at 3:15 a.m. and gave no further orders. D.V. was unable to void, so a catheter was placed. Although respondent saw D.V. again at 10:00 a.m., 3:00 p.m. and 6:00 p.m., no orders were given concerning the large hematoma.

20. After 6:30 p.m. on September 10, 1984, the patient was taken to the operating room, and the hematoma was drained, and D.V. went into hemorrhagic shock. She was transfused with three units of blood and placed on intramuscular and oral antibiotics. Respondent failed to do a thorough examination of the genital tract after delivery and failed to appropriately manage the lesion presented.

21. Respondent's management and care of patient D.V. as above described constitutes gross negligence and/or negligence and/or incompetence and therefore is cause for disciplinary action pursuant to section 2234(b), (c) and/or (d).

SIXTH CAUSE FOR DISCIPLINARY ACTION

22. Following respondent's delivery of her third child in November 1984, patient B.G., a 21 year old female adult, requested that respondent perform a tubal litigation. Respondent had provided prenatal care for B.G.'s three children; in each case, he performed no routine tests and took no thorough history, and prenatal visits were few.

23. On or about January 17, 1985, respondent performed a vaginal tubal litigation on B.G.; a segment of the left fallopian tube was removed, but the right tube was only clipped. Respondent took no record of the last menstrual period,

or of any birth control practiced by B.G., nor did he perform a serum pregnancy test prior to the tubal ligation. No dilation and curettage was recommended or performed at the tubal ligation, although an "enlarged" left ovary was aspirated of 4 to 5 cc of bloody fluid. In fact, B.G. was pregnant at the time the tubal ligation was performed, and the child was born on October 3, 1985.

24. Respondent's management and care of patient B.G. as described above constitutes gross negligence and/or negligence and/or incompetence and therefore is cause for disciplinary action pursuant to section 2234(b), (c) and/or (d).

SEVENTH CAUSE FOR DISCIPLINARY ACTION

25. On or about March 26, 1985, K.J., a 32 year old primagravida at term, went into labor at approximately 5:00 a.m. with respondent and a midwife called to attend her at a home birth. Respondent had monitored K.J. prenatally from six months gestation with notations only of weight, and only eight visits. Labor progressed extremely slowly, and at approximately 2:00 a.m. on March 27, 1985, K.J. was 7 cm dilated. She had become dehydrated from vomiting. Respondent had apparently checked fetal heart tones three or four times during labor, but no blood pressure was taken until after 2:30 a.m. on March 27th, immediately before which time, K.J. had had a grand mal seizure; blood pressure was found to be 140/90. Fetal heart tones diminished and there was definite bradycardia. Respondent failed to recognize or appropriately respond to dysfunctional labor and eclampsia.

26. K.J. was then taken to Community Hospital of Santa Rosa by ambulance, arriving at 3:15 a.m., when her blood pressure was measured at 150/90. While waiting for an operating crew to arrive for a caesarian section, K.J. experienced a second grand mal seizure, after which fetal heart tones dropped briefly. Respondent with the assistance of the chief obstetrical resident, performed a caesarian section commencing at approximately 3:45 a.m. K.J.'s blood pressure varied from 160/100 to 190/100 during and after surgery.

At the time of delivery, there was extremely thick meconeum staining; Apgars on the male infant were 0 and 1 at birth. Despite immediate aspiration by the pediatrician, the infant developed severe meconeum aspiration and birth asphyxia and died on April 1, 1985 from complications of these conditions.

27. Respondent's management and care of patient K.J. and her fetus/infant boy as described above constitutes gross negligence and/or incompetence and therefore is cause for disciplinary action pursuant to section 2234(b), (c) and/or (d).

EIGHTH CAUSE FOR DISCIPLINARY ACTION

28. On or about July 29, 1985 at approximately 9:00 a.m., C.M. a 21 year old primagravida, was admitted to Santa Rosa Memorial Hospital by respondent one week before her expected date of confinement (EDC). The patient had complained of nausea, vomiting, pedal edema, and headaches. Respondent's office examination revealed pedal edema, blood pressure of 130/88 and 4+ proteinuria. Previous prenatal appointments noted no tests for or assessments of proteinuria, hypertension or edema, although

the patient had experienced nausea, vomiting, diarrhea and upper abdominal pain periodically for some weeks before admission.

29. Despite steady worsening of the patient's condition, respondent did not monitor or evaluate her condition and waited at least 36 hours before beginning MgSO4 treatment. Labor was not induced despite severe pre-eclampsia. On or about July 30, 1985 the day after her admission, at 10:30 p.m., C.M. spontaneously ruptured her membranes and had a blood pressure of 180/120. MgSO4 and hydralazine were administered for blood pressure control but were stopped after delivery at 9:15 a.m. on July 31, 1985, following which C.M. developed hyaline casts in her urine and a drop in urine output.

30. Respondent's management and care of patient C.M. as described above constitutes gross negligence and/or negligence and/or incompetence and therefore is cause for disciplinary action pursuant to section 2234(b), (c) and/or (d).

NINTH CAUSE FOR DISCIPLINARY ACTION

31. On or about July 12, 1983, M.P., an 18 year old male, consulted respondent for a sore throat and fever. Respondent failed to perform a history and physical examination, and so gave M.P. an injection of penicillin and oral penicillin, even though the patient was allergic to this antibiotic. Respondent diagnosed the condition as tonsillitis and failed to take a temperature or throat culture. On July 13, 1983, M.P. was unimproved, so respondent placed him on oral Unipen, a penicillin derivative, and was told to return on July 15, 1983.

32. On July 15, 1983, respondent was informed that M.P. was vomiting, and the fever had not improved. Respondent admitted M.P. to Warrack Hospital in Santa Rosa at 3:00 a.m., M.P. was started on IV Keflin, another penicillin related antibiotic, starting at 10:14 a.m. and pain medication. M.P. became worse, with his fever spiking as high as 103.8 degrees F. Respondent was informed that a screen for infectious mononucleosis was positive, and hospital throat cultures grew pseudomonas and hemophilus influenzae. Without further examination of the patient after the initial admission and without consultation with an ear/nose/throat specialist, respondent signed out to his covering physician that afternoon without informing him about the hospitalized patient or the seriousness of his condition. M.P. died suddenly at midnight. Autopsy results indicated that M.P. died primarily from complications of infectious mononucleosis.

33. Respondent's care and management of patient M.P. as described above constitutes gross negligence and/or negligence and/or incompetence and therefore is cause for disciplinary action pursuant to section 2234(b), (c) and/or (d).

TENTH CAUSE FOR DISCIPLINARY ACTION

34. On or about June 12, 1983, patient J.M. was brought to Santa Rosa Memorial Hospital Emergency Room after a motorcycle accident. He complained of bilateral hand pain, and the emergency room physician ordered lateral films of the cervical spine, which were read as normal. Respondent then took charge of J.M. and admitted him to the hospital. A CT scan of

the brain and spinal x-rays were normal. Respondent placed J.M. on analygesics and physical therapy, but severe back pain, immobility, and weakness in the right upper extremity persisted. Despite this, respondent scheduled J.M. for discharge on June 29, 1983. Respondent had obtained no neurological consultation, nor had he documented a thorough neurological examination.

35. On June 29, 1983, at the request of J.M.'s physical therapist, a rehabilitation specialist examined J.M. and this specialist requested a neurological consult. After appropriate tests, J.M. was diagnosed as having a fracture subluxation of the C6 and C7 vertebrae for which an anterior cervical fusion and decompression were performed on July 7, 1983. In addition, a transposition of the right ulnar nerve was done on August 1, 1983. After further physical therapy, J.M. returned to work in November of 1983.

36. Respondent's care and management of patient J.M. constitutes gross negligence and/or negligence and/or incompetence and therefore is cause for disciplinary action pursuant to section 2234(b), (c) and/or (d).

ELEVENTH CAUSE FOR DISCIPLINARY ACTION

37. The factual allegations of the foregoing First through Tenth causes for disciplinary action, inclusive, are incorporated herein by reference.

38. Respondent's conduct as alleged above whether singlely, jointly or in any combination thereof constitutes gross negligence and/or repeated negligent acts and/or

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incompetence and therefore is cause for disciplinary action pursuant to section 2234(b), (c) and/or (d).

DRUG VIOLATIONS

BUSINESS AND PROFESSIONS CODE

39. Section 725 provides, in part, that repeated acts of clearly excessive prescribing or administering of drugs or treatment, as determined by the standard of the local community of licensees, is unprofessional conduct for a physician and surgeon.

40. Section 2238 states that:

> "A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating * * * dangerous drugs * * * or controlled substances constitutes unprofessional conduct."

41. Section 2241 provides in part that prescribing dangerous drugs or controlled substances to an addict or habitue constitutes unprofessional conduct.

42. Section 2242 provides, in pertinent part, that prescribing, dispensing, or furnishing dangerous drugs as defined in section 4211 without a good faith prior examination and medical indication therefor, constitutes unprofessional conduct.

43. Section 4211, defining a dangerous drug, provides, in pertinent part, that:

> " 'Dangerous drug' means any drug unsafe for self-medication, except veterinary drugs which are labeled as such, and includes the following:
>
> "(a) Any drug which bears the legend: 'Caution: federal law prohibits dispensing without prescription * * *, or words of similar import.
>
> "(b) Any device which bears the statement: 'Caution: federal law restricts this device to sale

by or on the order of a _____.' or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device * * *.

"(c) Any other drug or device which by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to section 4240."

HEALTH AND SAFETY CODE

44. Section 11168 of the Health and Safety Code states that the prescription book containing the prescriber's copies of prescriptions issued shall be retained by the prescriber which shall be preserved for three years.

45. Section 11171 of the Health and Safety Code states that no person shall prescribe, administer, or furnish a controlled substance except under the conditions and in the manner provided by this division.

46. Sections 11190 and 11191 of the Health and Safety Code describing a practitioner's duty to keep records, states that in addition to preserving such records for three years:

"* * * Every practitioner, other than a pharmacist, who issues a prescription, or dispenses or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:

"(a) The name and address of the patient.

"(b) The date.

"(c) The character and quantity of controlled substances involved.

"* * * The prescriber's record shall show the pathology and purpose for which the prescription is issued, or the controlled substance administered, prescribed, or dispensed."

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DRUGS

47. Ionamin is the trade name for the generic substance phentermine resin which is a dangerous drug as defined under section 4211.

48. Tenuate Dospan is the trade name for the generic substance diethylpropion which is a dangerous drug as defined under section 4211 and a Schedule IV controlled substance as defined in 21 CFR section 1308.14(d)(1).

49. Valium is the trade name for the generic substance diazepam and is a dangerous drug as defined under section 4211 and a Schedule IV controlled substance as defined under Health and Safety Code section 11057(d).

50. Cortisporin is the trade name for the generic substance polymyxin B-bacitracin-neomycin-hydrocortisone and is a dangerous drug as defined under section 4211.

51. Retin-A is the brand name for the generic substance containing tretinoin and is a dangerous drug as defined under section 4211.

52. Percodan is the trade name for the generic substance dihydroxycodeinone and is a Schedule II controlled substance as defined in Health and Safety Code section 11055(b)(1) and is a dangerous drug as defined under section 4211.

53. Tuinal is the trade name for the generic substance combining amytal and secobarbital and is a Schedule III controlled substance as defined in Health and Safety Code section

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11056(b)(1) and a Schedule II controlled substance under federal regulation 21 CFR section 1308.12(e)(2) and (3).

54. Seconal is the trade name for the generic substance secobarbital and is a Schedule III controlled substance as defined in Health and Safety Code section 11056(b)(1) and is a dangerous drug as defined in Business and Professions Code section 4211.

55. Nembutal is the trade name for the generic substance pentoparbital sodium and is a Schedule III controlled substance as defined in Health and Safety Code section11056(b)(1) and is a dangerous drug under section 4211.

56. Amytal is the trade name for the generic substance amobarbital and is a Schedule II controlled substance as defined in Health and Safety Code section 11055 and is a dangerous drug as defined under section 4211.

TWELFTH CAUSE FOR DISCIPLINARY ACTION

57. On or about the dates listed below, respondent prescribed controlled substances and/or dangerous drugs to the persons named and in the amounts indicated:

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PATIENT NAME:	V.G.		
DATE	**TYPE OF DRUG**	**STRENGTH**	**QUANTITY**
10/04/83	Nembutal/Seconal	100 mg	100
12/23/83	Nembutal/Seconal	100 mg	100
05/02/84	Nembutal/Seconal	100 mg	100
06/22/84	Nembutal/Seconal	100 mg	100
08/23/84	Nembutal/Seconal	100 mg	100
10/17/84	Nembutal/Seconal	100 mg	100
PATIENT NAME:	B.J.J.		
DATE	**TYPE OF DRUG**	**STRENGTH**	**QUANTITY**
06/13/84	Nembutal/Seconal	100 mg	30
07/26/84	Nembutal/Seconal	100 mg	30
09/05/84	Nemutal/Seconal	100 mg	20
09/05/84	Percodan	5 mg	30
11/14/84	Nembutal/Seconal	100 mg	30
06/04/85	Percodan		30
06/05/85	Tuinal Pulvule		30
07/27/85	Percodan		30
07/27/85	Tuinal Pulvule		30
08/12/85	Percodan		30
08/12/85	Tuinal Pulvule		30
08/26/85	Percodan		30
PATIENT NAME:	T.F.		
DATE	**TYPE OF DRUG**	**STRENGTH**	**QUANTITY**
11/03/84	Percodan	5 mg	20

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PATIENT NAME: S.F.

DATE	TYPE OF DRUG	STRENGTH	QUANTITY
12/12/84	Cortisporin Ophthalmic Ointment		4 oz
03/11/85	Retin-A Cream, 1%		4 oz
03/11/85	Valium, 10 mg		30
03/22/85	Retin-A Cream, .05%		2 oz
03/22/85	Adipex P (Ionamin), 30 mg		100

PATIENT NAME: K.R.

DATE	TYPE OF DRUG	STRENGTH	QUANTITY
04/20/85	Tenuate Dospan, 75 mg		100 (dispensed 25)
09/20/85	Tenuate Dospan, 75 mg		(dispensed 15)
10/24/85	Tenuate Dospan, 75 mg		15
11/21/85	Tenuate Dospan, 75 mg		10

PATIENT NAME: J.K.

DATE	TYPE OF DRUG	STRENGTH	QUANTITY
10/05/83	Percodan	5 mg	30
10/14/83	Percodan	5 mg	30
12/05/83	Percodan	5 mg	30
12/19/83	Percodan	5 mg	30
02/24/84	Percodan	5 mg	30

03/12/84	Percodan	5 mg	30
03/26/84	Percodan	5 mg	30
04/09/84	Percodan	5 mg	30
04/20/84	Percodan	5 mg	30
04/27/84	Percodan	5 mg	30
05/23/84	Percodan	5 mg	30
06/05/84	Percodan	5 mg	30
06/11/84	Percodan	5 mg	40
06/25/84	Percodan	5 mg	30
07/11/84	Percodan	5 mg	30
07/19/84	Percodan	5 mg	30
07/31/84	Percodan	5 mg	30
08/05/84	Percodan	5 mg	30
08/15/84	Percodan	5 mg	30
08/24/84	Percodan	5 mg	30
08/31/84	Percodan	5 mg	30
09/07/84	Percodan	5 mg	30
09/12/84	Percodan	5 mg	30
09/25/84	Percodan	5 mg	30
10/09/84	Percodan	5 mg	30
10/17/84	Percodan	5 mg	30
10/26/84	Percodan	5 mg	30
10/31/84	Percodan	5 mg	30
11/07/84	Percodan	5 mg	40
11/21/84	Percodan	5 mg	30

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PATIENT NAME: G.S.

DATE	TYPE OF DRUG	STRENGTH	QUANTITY
10/13/83	Nembutal/Seconal	50 mg	100
12/05/83	Nembutal/Seconal	50 mg	100
02/02/84	Nembutal/Seconal	50 mg	100
03/01/84	Nembutal/Seconal	50 mg	100
03/01/84	Nembutal/Seconal	50 mg	100
05/02/84	Nembutal/Seconal	50 mg	100
05/31/84	Nembutal/Seconal	50 mg	100
07/02/84	Nembutal/Seconal	50 mg	50
08/01/84	Nembutal/Seconal	50 mg	150
09/04/84	Nembutal/Seconal	50 mg	100
10/01/84	Nembutal/Seconal	50 mg	100
10/31/84	Nembutal/Seconal	50 mg	100
12/31/84	Amytal	50 mg	100
01/31/85	Amytal	50 mg	100
02/28/85	Amytal	50 mg	100
04/01/85	Amytal	50 mg	100
05/01/85	Amytal	50 mg	100
05/30/85	Amytal	50 mg	100
06/27/85	Amytal	50 mg	100
07/29/85	Amytal	50 mg	100
08/29/85	Amytal	50 mg	100
09/26/85	Amytal	50 mg	100

58. Respondent maintained no prescribing records or patient records for T.F., S.F., and K.R. Prescribing the controlled substances and/or dangerous drugs for these persons,

as alleged in paragraph 57, without maintaining appropriate records, is a violation of Health and Safety Code sections 11168, 11171, 11190 and 11191, and therefore is unprofessional conduct under section 2238 and grounds for disciplinary action under section 2234.

59. Respondent prescribed the controlled substances and/or dangerous drugs to S.F., T.F., K.R., G.S., V.G., B.J.J. and J.K., as alleged in paragraph 57, without a good faith prior examination and medical indication therefor, which is unprofessional conduct as defined in section 2242. Grounds for discipline are stated under that section in conjunction with section 2234.

60. Respondent prescribed the dangerous drugs and/or controlled substances as alleged in paragraph 57 to G.S., V.G., B.J.J. and J.K. who were addicts or habitues. Prescribing controlled substances and/or dangerous drugs to an addict or habitue is unprofessional conduct under section 2241. Grounds for discipline are stated under that section in conjunction with section 2234.

61. The conduct as alleged in paragraph 57 through 60 constiutes repeated acts of clearly excessive prescribing or administering of drugs as determined by the standard of the community and which is unprofessional conduct as defined in section 725. Grounds for discipline are stated under that section in conjunction with section 2234.

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WHEREFORE, complainant prays that the Board hold a hearing on the matters alleged herein and following said hearing issue a decision suspending or revoking the physicians' and surgeons' certificate No. C-20725 issued to Calvin Stanley Steever, M.D., and take such other and further action as the Board deems proper.

DATED: February 4, 1988

KENNETH J. WAGSTAFF
Executive Director
Board of Medical Quality Assurance
Division of Medical Quality
State of California

Complainant